

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009639

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2228

STATE FILE NUMBER

| | | | |
|---|-----------------------------|---|----------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived.) If institution: Residence before admission) a. STATE MO. b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Length of stay in 1b 3 mos. 9 days | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. STREET ADDRESS 8335 - 5th Ave., | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last SALLIE WILLOUGHBY | | 4. DATE OF DEATH Month Day Year Feb. 24, 1963 | |
| 5. SEX Female | 6. COLOR OR RACE Negress | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-7-83 |
| 9. AGE (last birthday) 80 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (City and state or country) Hollygrove, Ark. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME John W. Dennis | | 13b. MOTHER'S MAIDEN NAME ? Kizahia (??) | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | |
| 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Records of St. Louis State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Volvulus with gangrene; DUE TO (b) Fibrous adhesions DUE TO (c) 570.3 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) A.S.H.D. PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | INTERVAL BETWEEN ONSET AND DEATH 72 hrs | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from 11-15-62 to 2-24-63 and last saw her alive on 2-24-63 Death occurred at 7:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Signature or title) Deceased Husband | |
| 22b. ADDRESS 5400 Arsenal St. | | 22c. DATE SIGNED 2-26-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 1 Mar/63 | |
| 23c. NAME OF CEMETERY OR CREMATORY Washington Park | | 23d. LOCATION (City, town, or county) (State) St. Louis County | |
| 24. FUNERAL DIRECTOR Boyd Bros Funeral Home | | 25. DATE RECD. BY LOCAL REG. FEB 27 1963 | |
| 26. REGISTRAR'S SIGNATURE Road Smith. M.D. | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

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240282

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3000 8 11102117

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Henry C. Williams

Licensed Embalmer No. 4781

P. O. Address 1205 W 121st

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.